Transparency	**Background:** The Commission explored whether price transparency would serve to reduce health care costs. Some literature reviewed by the Commission (will identify/ list sources in appendices) reflects: • That increased transparency of provider costs, when the information is made available in a publically accessible format, results in lower pricing by providers whose charges are significantly higher than the norm. • When data is made available to primary care providers at the point of care combined with a value-based payment, it has been shown to result in lower spending and higher quality. • Consumer behavior with respect to health care is not driven solely or even principally by cost, but by a number of considerations, including the recommendation of their providers, where they may receive in network care, and convenience. ○ Without information about quality, and without clear, meaningful, and accessible information generally not currently available, price transparency has not had a significant effect to-date on patient behavior. The Commission acknowledged that for transparency to benefit consumers, information about health care costs must be presented in a place and form that is accessible and understandable - especially as consumers continue to assume more financial responsibility in the cost of their care. Sources: 1. Jon B. Christianson and Roger Feldman, Evolution In The Buyers Health Care Action Group Purchasing Initiative Health Affairs, 21, no.1 (2002):76-88 2. Health Affairs, Health Policy Brief, Public Reporting on Quality and Costs. Do report cards and other measures of providers' performance lead to improved care and better choices by consumers?, March 2012 3. Peter S. Hussey, Public Reporting of Provider Performance at a Crossroads in the United States: Summary of Current Barriers and Recommendations on How to Move Forward, Medical Care Research and Review Supplement to 2014, Vol. 71(5) 5S –16S. 4. Health Policy Institute of Ohio, Health Data Transparency Basics, March 2012. 5. Undetermined impact of patient decision support interventions on healthcare costs and savings: systematic review, BMJ 2014;348:g188 doi: 10.1136/bmj.g188 (Published 23 January 2014) **Potential Recommendations:** • Create more transparent and publicly available data with a focus primarily around facilities and providers' prices using resources including but not limited to APCD. Data should be timely and regularly updated for the public. • Transparency should include quality, price, and a choice of options that are available - a system that helps people and payers make choices based on clinical outcomes as well as price. • The Commission supports the work of the APCD and feels that the data it will provide can help guide the discussion around cost going forward

	• Provide data to providers and clinicians at point of service. • Support a statewide total cost of care initiative (payments) to get an understanding of state costs relative to others. • A patient understands patient responsibility and accountability, and options related to cost and care especially as it relates to balance billing. If a patient has a significant financial requirement or if the patient controls where money goes, transparency is important and will likely impact their decision making (it should be noted that virtually all cash, direct pay, and concierge practices publish their prices). • Transparency is beneficial to more than just consumers. It is important to payers as well to understand similar provider groups and how they render services, and have a consistent metric for pricing. • The Commission recognized the importance of price transparency as it relates to pharmaceuticals. • A broad use of transparency tools (i.e. pivot tables, other tools) by the DOI, HCPF, and CIVHC that can be posted on a website for all citizens to access which show costs by provider, and quality outcomes.
	Parking Lots Items: • This warrants more attention, including possibly utilizing an advisory committee dedicated to the topic of transparency. Important to get the on-the-ground sentiment related to this topic. • Strengthen the state's ability to provide Explanation of Benefits (EOB) to clients when they incur a charge to identify potential provider fraud. • Align with value based payment efforts (needs to be defined). Develop a shared common understanding of quality versus cost (metric), to be a better purchaser. • Disclosure and the publishing of fees/ taxes imposed on providers.
Workforce	**Background:** The Commission explored what role workforce played in the cost of care. Some literature reviewed by the Commission (will identify/ list sources) indicates that many health care professionals are not performing work reflecting the fullest extent of their education and training. It appears this is largely due to the various regulations and restrictions which impede such expansions. The time that a physician spends performing a task that a nurse practitioner (NP), physician assistant (PA), physical therapist (PT), pharmacist, or other health professional is qualified to perform unnecessarily drives up health care costs. Data indicates that the lack of accessible primary care professionals, or the lack of primary care professionals willing to accept publically insured patients, may drive patients to seek specialists for the delivery of primary care services, or drive patients to seek emergency health services for routine care. A 2012 study found that two in five American adults receive primary care services from specialists. *Additionally, research suggests that the increased availability of specialists lead to higher costs.* Studies have shown that health care spending is higher in regions with a larger proportion of physician specialists. A career in specialty medicine, such as orthopedics or dermatology, requires more education but leads to greater financial rewards over the long term. The promise of substantially higher income, which also increases ability to pay off their student loan debts, creates an incentive for medical students to pursue specialty care. In addition, Colorado

	developed a Health Workforce Development Strategy reflective of voices from more than 100 individuals representing more than 50 separate organizations from a myriad of disciplines and areas of expertise.
	
	Sources:
	1. PricewaterhouseCoopers' Health Research Institute, What works*: Healing the healthcare staffing shortage, 2007
	2. Bi-Partisan Policy Center, What Is Driving U.S. Health Care Spending? America's Unsustainable Health Care Cost Growth, September 2012
	3. F. Isasi and E. Krofah. The Expanding Role of Pharmacists in a Transformed Health Care System, National Governors Association Center for Best Practices, January 13, 2015
	4. Catherine Dower, Jean Moore and Margaret Langelier, It Is Time To Restructure Health Professions Scope-Of-Practice Regulations To Remove Barriers To Care, Health Affairs, 32, no.11 (2013):1971-1976
	5. Kale, M.S., et al. "Visits for Primary Care Services to Primary Care and Specialty Care Physicians, 1999 and 2007." Archives of Internal Medicine. August 2012
	
	Potential Recommendations:
	• Support and allow people to have meaningful access to primary care service. Including but not limited to:
	  ○ Supporting health care professionals being able to practice at the top of their scope of practice.
	  ○ Improving the supply and practice of nonprofessional individuals such as community health workers and other community members that can support efficient and cost effective community based delivery models.
	• Develop a workforce policy body that aligns state efforts, data sets, and assesses community needs to assess workforce needs on-going.
	• Request revisions to the federal Graduate Medical Education (GME) programs rules and regulations.
	  ○ Seek additional slots in training programs in areas of CO workforce need.
	  ○ Seek flexibility in GME requirements, especially in primary care, rural, and underserved training programs.
	• Investigate pathways to assist health care professionals seeking to rapid entrance to the CO workforce and for those that are foreign trained.
	• Promote and support health care providers practicing in identified rural and underserved areas by increasing funding, eligibility, and policies for efforts that reduce debt load for those willing to serve in these areas including but not limited to the Colorado Health Service Corps.

	Parking Lots Items: • Evaluate the adequacy of reimbursement for primary care and how that impacts access. • Fund primary care adequately (incentives). • Continue the Medicaid primary care provider bump in reimbursement rates. • Align workforce efforts with value based payment efforts.

Payment and Delivery Reform	The Commission explored the role that payment and delivery reform plays in reducing the cost of care. The State of Colorado employees and commercial employers, in their capacities as payers and purchasers, have a key role to play in shifting to payment structures that reward high quality care and reduce the volume incentives inherent in fee-for-service reimbursement. Experimentation in these sectors should be encouraged. Simultaneously, it is also important to understand that traditional capitation (as applied in the late 1980's) may also not be the answer. Payment reform, particularly when multiple payers work together, offers the potential not only for promoting value in health care but also for supporting new delivery models that better integrate providers and services and increase providers' accountability for unnecessary variation in utilization and costs for specific services. There are many new forms of payment emerging today and these each need to be studied as potential ways to better align payment and continuity of quality care. At this point no one, single approach appears to be ideal. We expect these multiple approaches to morph, over time.
	
	Sources:
	1. Health Affairs Policy Brief, Pay-for-Performance. New payment systems reward doctors and hospitals for improving the quality of care, but studies to date show mixed results, October 2012
	2. CIVHC, New Approaches to Paying for Health Care: Implications for Quality Improvement and Cost Containment in Colorado, July 2012
	3. Mark Fendrick, Jenifer J. Martin, and Alison E. Weiss, Value-Based Insurance Design: More Health at Any Price, Health Services Research, DOI: 10.1111/j.1475-6773.2011.01358.x
	4. Mark Fendrick, MD; and Michael E. Chernew, PhD, Value Based Insurance Design: Maintaining a Focus on Health in an Era of Cost Containment, www.ajmc.com, June 2009
	
	Recommendations:
	• Support efforts to align the use of common quality metrics across payers in order to drive value-based payment models and enhance public reporting of provider performance on quality and costs
	• Encourage experimentation with new forms of pricing and reimbursement including but not limited to:
	  ○ Use of reference pricing for all payers
	  ○ Condition-based payments;
	  ○ Episode of payment for a procedure; and
	  ○ Warrantied payment for services
	• Adoption of bundled methodologies as appropriate for all payers including in the State's employees' purchase of certain procedures and conditions.
	  ○ Pilot a bundled payment methodology for:
	  ▪ State employees: Hips and knees, back surgery and congestive heart failure
	  ▪ Pre-Medicare state retirees: Continue for hip and knee replacements, pilot for back surgery and congestive heart failure

	• Adoption of payment structures in Medicaid, such as braided or bundled funding, that address clients' social determinants of health
	  ○ Merge or more meaningfully align state agencies (health authority)
	  ○ Braid funding for housing
	  ○ Expand Medicaid ACC medical home model to braid in funding for social services
	• Study traditional rate-setting for all payers and global budgets for all hospitals as well as for Medicare and commercial payers in rural hospitals
	• Implementation of public reporting and fiscal incentives for provider cost and outcome performance based on claims data analysis
	• Encourage experimentation with new forms of pricing and reimbursement in arenas such as:
	  ○ Use of reference pricing for all payers
	  ○ Further expand of Bundled payment in PERA
	• Expand programs that invest more in primary care in order to reduce hospital utilization to other RCCO regions
	• Adoption of VBID (Value Based Insurance Design) approach to benefit design for all payers including the State's employees, (e.g., high value services with low or no copay, lower value services with higher copays, etc.)
	• Enhance primary care reimbursement using value-based models like the PCMH and integrated care models, and include adequate funding to fully implement these systems.

	Parking Lots Items: • Assessment of the various types of evolving reimbursement models • Set a state target for increased system-wide spending on primary care, which has been shown to lower overall health care costs in R.I. • Encourage the Direct Primary Care model.
Market Competitiveness	Background: Sources: 1. Martin Gaynor and Robert J. Town, Competition in Health Care Markets, NBER Working Paper No. 17208, July 2011, JEL No. I11,I18,L10,L13,L30,L40 2. Christopher M. Pope, PhD, Legislating Low Prices: Cutting Costs or Care?, Heritage Foundation, No. 2834, August 9, 2013 3. Daniel P. Kessler, The Effects of Pharmaceutical Price Controls on the Cost and Quality of Medical Care: A Review of the Empirical Literature, Stanford University, Hoover Institution, and the National Bureau of Economic Research, 2004 4. Danzon, Patricia M. and Keuffel, Eric L., "Regulation of the Pharmaceutical Biotechnology Industry," 2007, http://core.ac.uk/download/pdf/6654017.pdf.

	5. R. E. Hall and C. I. Jones, "The Value of Life and the Rise in Health Spending," The Quarterly Journal of Economics 122, no. 1 (February 1, 2007): 39–72, doi:10.1162/qjec.122.1.39. 6. Anirban Basu, Anupam B. Jena, and Tomas J. Philipson, "The Impact of Comparative Effectiveness Research on Health and Health Care Spending," Journal of Health Economics 30, no. 4 (July 2011): 695–706, doi:10.1016/j.jhealeco.2011.05.012. 7. Anirban Basu et al., "Heterogeneity in Action: The Role of Passive Personalization in Comparative Effectiveness Research: Heterogeneity in Action," *Health Economics* 23, no. 3 (March 2014): 359–73, doi:10.1002/hec.2996. 8. Robert A. Berenson, M.D., Healthcare Consolidation: Winners, Losers, and Policy Implications, Urban Institute, November 2015 Recommendations: •
	Parking Lots Items: •
Social Determinants	Background: Sources: **Recommendations:** • Enhanced per Member per Month (PMPM) payment through the RCCO's for high need, high cost complex patients, who have been identified as such through Statewide Data Analytics Contractor (SDAC) data, hospitals, healthcare organizations, community mental health centers. The PMPM would pay for the multidisciplinary team of a Medical provider (NP/PA), Behavioral health provider, Care coordinator, health coach, and a hospital based community health worker. The team would work intensely with the patient and link (or re-link) them into a medical home in the community once the patient completes the program. Should consider a shared PMPM for PCP and facility for care coordination. Metrics could then look at admission and ED visit rates. After program maturation there could be incentive metrics for performance to earn part of the PMPM. Core components for success include: ○ Close hospital partnerships for real time referrals and bedside enrollment ○ Behavioral health therapist as part of the team ○ Access to data: claims data, cost and utilization, and pre/post assessment for PH/BH capabilities within one EMR. • Pursue a Delivery System Reform Incentive Payment (DSRIP) Program Amendment to the State's Section 1115 Medicaid Demonstration Waiver to align with goals of the Colorado Opportunity Project (COP) • Increased investments in Nurse Family Partnership (Every $1 spent savings of $5.70 for high-risk mothers; $1.26 for low-risk mothers)

	• Create a pilot to identify urban, low-income patients with asthma from zip codes with high Emergency Department (ED) visits or hospitalizations due to asthma, and offer enhanced care including nurse case management and home visits. • Funding mechanisms for ACEs/ toxic stress? • *Support for actuarial work for public health to quantify value of their work (more formulaic)*
	Parking Lots Items: •
Regulatory Costs	**Recommendations:** •
	Parking Lots Items: •
Administrative Costs	**Recommendations:** •
	Parking Lots Items: •
Technology	**Recommendations:** •
	Parking Lots Items: •
Incentive Mechanisms	**Recommendations:** •
	Parking Lots Items: •
Other topics: Pharmaceuticals	